

Quality Assessment



Implementing Performance Improvement and Measuring Psychiatric Care Quality

by Geetha Jayaram, MD, MBA

Increasingly, physicians and medical institutions are being asked to demonstrate care quality by documenting performance measurement against national benchmarks,¹⁻³ necessitating changes in the structure of systems and methods of evaluating them for

outcomes. A cardiac care goal, for example, is to administer or prescribe aspirin at discharge for a patient with myocardial infarction or to advise smoking cessation. Payment percentages to physicians or hospitals may be reduced or withheld until the goal is met.⁴ Key elements of such

programs are noted by Rosenthal in a recent issue of the *Journal of the American Medical Association*.⁵ However, there is neither widespread consensus nor agreement on what to measure and when, who will be responsible for each intervention, how to document such measures, or how to standardize them for various care settings. Care providers also must decide which populations are at risk, synthesize efficacy results from clinical trials with obstacles to overcome in the real world setting, and target the most remunerative or critical disease or procedure to monitor. Also, setting up or modifying care processes in a busy clinical setting, instituting information technology support systems, and training staff is a costly venture. Who pays for these efforts? Do they always pay off?

Performance standards vary by clinical setting, case-mix of populations treated, type of hospital, those on Medicaid versus private pay, sampling strategies, and databases examined.^{4,5} Successful private practitioners with excellent patient retention records are seldom examined in order to disseminate “best practices” results. Physician records for recredentialing are neither uniformly maintained nor are they available for public scrutiny.³

PSYCHIATRIC INDICATORS

Let us take the example of suicidal patients, a group that gravely concerns the Committee on Patient Safety at the American Psychiatric Association.⁶ Although Hawton and colleagues have demonstrated the need for close follow-up of patients with affective disorders soon after discharge from a hospital and have shown that male patients between the ages of 18 and 64 are at the highest risk, few community-based clinics or insurance companies incorporate these findings systematically by

providing an appointment soon after discharge.⁷ Nor do they seek information on whether the patient is in the most vulnerable category at intake.

Yet another example: A cognitively limited patient whose limitations are newly diagnosed, who lives alone, who is no longer depressed, but who cannot manage by herself outside the hospital and is not “authorized” for continued hospital care, is at extended risk of continued hospitalization, posing greater risk for resource use. How is the quality judged in this case? Who has the fiduciary responsibility for her care? How do we tie payment for the extra

measurement better than therapy. One could set up benchmarks for noncognitive complications for ECT, establish numbers for excellence in care, and study the procedure for the interventions that make a difference. For example, does the use of adequate antihypertensives (defined by readings) prior to treatment prevent strokes? The thresholds, of course, will have to be agreed upon.

Falls causing significant injury in the elderly, elopements of dangerously ill patients who have been certified, rates of restraint and seclusion use for severely ill patients classified by case mix and illness severity, and medication errors among commonly

It is only a matter of time before revenue streams from third-party payers is examined for the practice of psychiatry and linked to performance expectations by benchmarks, guidelines, and norms.

Regulations, current revenue streams, rising malpractice costs, emphasis on pay-for-performance, and dilution of physicians’ roles with administrative responsibilities have necessitated the development of time-consuming performance improvement programs in major hospitals. These programs address performance dimensions of credentialing, risk management, documentation, reduction in adverse

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supervised care to the appropriate assessment of her cognitive limitations, which ultimately delays discharge? How can we measure failures in the quality of transitions between systems?

An evidence-based measure for assessment of suicidal patients could be the number of patients with major depression and/or suicidal ideation or attempts that are treated, and subsequent mortality among them, as compared to population norms or similar treatment centers with broad physician consensus. How can we accurately collect these data? Given that suicide is a grave but low occurrence event, a very large sample would be required to test outcomes, making the task onerous. Patients also are not randomly assigned to physicians or services, particularly in psychiatry.

Procedures, such as electroshock therapy (ECT), lend themselves to

used psychotropic medications all lend themselves to evaluation, benchmarking, and systems interventions.⁸ Who sets the standards? How do we determine excellence? It may be possible to identify common errors among psychotropic medications if several institutions caring for different diagnostic and ethnic groups, both outpatients and inpatients, collaboratively reviewed their databases, made interventions, and tracked the problem. Outliers at both ends can be identified, and the best systems examined for processes that decrease error. This includes examinations of technology support systems for order entry. Staff can be trained to incorporate checks or failsafe mechanisms. The project must be ongoing to continue maintaining quality.⁹ Determining functional improvements in patients is yet another demonstration of care impact.

events, improvement of care processes, and finally, education of physicians and funding research.^{8,9}

In excellent hospital settings, continuous monitoring, repeated practice/root cause analyses, and examination of systems result in greater efficiency, effectiveness, timeliness, safety, and patient satisfaction, to name a few. Setting annual goals that apply to clinical service and quality as well as to hospital utilization management and performance goals is integral to this development.¹⁰ Similarly, outpatient psychiatric practice in community mental health centers has been examined for practice improvement.^{11,12} One goal applicable to patients with schizophrenia and major depression can be improving time to discontinuation of therapeutic agents. Published research serves as a benchmark in this area.¹³

RECOMMENDATIONS

How does a psychiatric care system proceed at this point? Some areas for consideration of psychiatric practice improvement (but not an exhaustive list) are as follows:

1. Assessments in the emergency department

- Complete medical assessment and medicating the patient
- Involvement of senior/attending MDs
- Containment of violence, risk of harm
- Family or significant other involvement
- Avoiding wrongful discharge or suicide
- Assessing/tracking communication needs to receiving units of service

2. Inpatient assessments

- Proper handover/handoff procedures
- Assessment of violence risk, seclusion/restraint need
- Evaluating hypersexuality, acting out, and other aggressive behaviors
- Routine substance abuse and medical assessments
- Medication errors
- Adverse reactions, adverse events
- Daily assessment of suicide risk
- Rapid discharges resulting in adverse outcomes

3. Evaluation in step-down systems (day hospital, after-care programs, substance abuse programs)

- Daily risk assessment of self harm or harm to others, particularly soon after discharge
- Assessing educational needs of the patient and caregivers
- Risk of relapse/assessment of adherence/appropriate interventions

- Care of the cognitively impaired patient, those with comorbidity
- Competency assessments
- Cost comparisons of interventions that are of equal outcome but different costs.

Beginning with the assessment of competency of all staff to render psychiatric care well, setting up an interdisciplinary framework of leadership to choose goals and a structure to gather data are crucial. This is discussed more in detail elsewhere.¹⁴

With careful, stepwise progression, data gathering systems can be set up incrementally to measure against oneself, if not against national benchmarks. The Plan-Do-Study-Act cycle described by Berwick¹⁵ may serve systems just as well as clinical trials in which carefully selected patient groups are studied. Managing internal systems in a collaborative manner, overcoming obstacles for deployment of ideas, and safe practices are described well by Batalden.¹⁶

A framework for psychiatric care assessment is as follows:

- Choose a few indicators by consensus
- Involve all disciplines, educate, and train staff on methods and processes
- Determine data collection—by whom, when and for how long, and on which patients
- Decide on broadly accepted evidence-based criteria
- Decide which are practitioner components and which are system components
- Collect data systematically, by objective means, representative of general practice in the area
- Include patients and/or families in care evaluations
- Examine results and trends, refine data collection, and provide feedback.

Psychiatry as a discipline lags behind other medical subspecialties in quality assessments because of the absence of procedures. Nevertheless, many interventions can be made with promising results to improve care delivery for our patients, reducing adverse outcomes.

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NEWS FROM MENTAL HEALTH AMERICA

The National Working Group on Evidence-Based Health Care

by David Shern, PhD
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In past columns, I have devoted considerable space to issues related to evidence-based healthcare. Simultaneously, Mental Health America has convened and continues to lead and expand a collaboration of over 40 patient and provider organizations to balance the evidence-based healthcare equation. The group, called The National Working Group on Evidence-Based Health Care, aims to keep science relevant to individuals by promoting and ensuring the role of patients in evidence-based healthcare policy through education and advocacy efforts. As we see it, individualized care—rather than singular reliance on generalizations gleaned from clinical trials—is the heart of effective, high-quality treatment. True evidence-based healthcare ensures that treatments are made by balancing cost with scientific evidence, physician judgment, and patient experience and preferences.

In April, The Working Group hosted a forum on the central role patients should play in evidence-based healthcare. In addition to hearing from patient and expert panelists, the forum featured several approaches that effectively include patient insight and preferences in healthcare decision-making, including the following:

- The UK's National Institute for Health and Clinical Excellence's (NICE) Patient and Public Involvement Programme conducts clinical and cost-effectiveness technology appraisals, provides guidance to the National Health Service on the use of new and existing technologies, and develops clinical practice and public health guidelines. The Patient and Public Involvement Programme identifies patient and caregiver organizations and lay people interested in providing input to NICE on guidance documents, as well as training to support their involvement. NICE's Citizens Council helps to integrate the general public into guidance.
- The US Food and Drug Administration's Patient Representative Program provides the FDA with the perspective of patients on therapies during their final review. The FDA's Drug Development Patient Consultant Program incorporates the perspective of patients into the drug development process through involvement in the drug regulatory review process. Patient representatives sit as both voting and non-voting participants in the FDA advisory committees that make recommendations to the FDA about new drugs and medical devices for marketing.
- Agency for Healthcare Research and Quality (AHRQ) Effective Healthcare Program conducts research on the outcomes and effectiveness of healthcare services and treatments. It works with academic centers nationwide to bring together existing data, conduct original research, and help the public learn about current available research. In addition, AHRQ's John M. Eisenberg Center at Oregon Health and Science University puts research into short, consumer-friendly guides that can be used by consumers and clinicians to convey findings about effectiveness, safety, and drug costs.

While the Working Group does not endorse any single approach to patient inclusion in decision-making, it sees these approaches as integral steps toward ensuring balance in evidence-based healthcare.

This group will continue to work with other stakeholders about how to engage patients with practitioners, researchers, academics, and decision makers and plans to translate the forum discussion into principles to guide all healthcare decision makers about how to involve patients and consumers in a meaningful way.

To learn more about evidence-based healthcare, listen to the forum webcast, or to become a member organization of the National Working Group on Evidence-Based Health Care, visit <http://www.evidencebasedhealthcare.org>. ●